Washington State Department of Health

Send completed forms to DOH Communicable Disease Epidemiology **Fax: 206-418-5515**

Cyclosporiasis

County

LHJ Use **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed** ☐ **Probable**
By: ☐ **Lab** ☐ **Clinical** ☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ***ID*** _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation start date: ___/___/___

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	**Diarrhea** Maximum # stools in 24 hours: ____
☐	☐	☐	☐	**Watery diarrhea**
☐	☐	☐	☐	**Abdominal cramps or pain**
☐	☐	☐	☐	Nausea
☐	☐	☐	☐	Weight loss with illness
☐	☐	☐	☐	**Bloating or gas**
☐	☐	☐	☐	**Fever** Highest measured temp (^{o}F): _____ ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk

Laboratory

P = Positive O = Other, unknown
N = Negative NT = Not Tested
I = Indeterminate

Collection date ___/___/___

P	N	I	O	NT	
☐	☐	☐	☐	☐	***Cyclospora*** **PCR (stool, duodenal aspirates, small bowel biopsy specimens)**
☐	☐	☐	☐	☐	***Cyclospora*** **oocysts (stool, intestinal fluid, small-bowel biopsy specimen)**
☐	☐	☐	☐	☐	***Cyclospora*** **sporulation**
☐	☐	☐	☐	☐	Food specimen submitted for testing

Predisposing Conditions

Y	N	DK	NA	
☐	☐	☐	☐	Immunosuppressive therapy or disease

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy Place of death _____

NOTES

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

Washington State Department of Health **Case Name:** _____

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count backward to determine probable exposure period

	Exposure period		
Days from onset:	-14	-1	onset
Calendar dates:			

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
- Out of: ☐ County ☐ State ☐ Country
- Destinations: _____
- Date left: _____
- Date returned: _____

☐ ☐ ☐ ☐ Case knows anyone with similar symptoms

☐ ☐ ☐ ☐ **Epidemiologic link to a confirmed human case**

☐ ☐ ☐ ☐ Raw fruits or vegetables
- Berries ☐**Y** ☐**N** ☐**DK** ☐**NA**
- Type: _____
- Fresh herbs ☐**Y** ☐**N** ☐**DK** ☐**NA**
- Type: _____
- Lettuce or salad greens ☐**Y** ☐**N** ☐**DK** ☐**NA**

Y N DK NA

☐ ☐ ☐ ☐ Group meal (e.g. potluck, reception)

☐ ☐ ☐ ☐ Food from restaurants

Restaurant name/location: _____

_____

_____

Y N DK NA

☐ ☐ ☐ ☐ Source of drinking water known
- ☐ Individual well ☐ Shared well
- ☐ Public water system ☐ Bottled water
- ☐ Other: _____

☐ ☐ ☐ ☐ Drank untreated/unchlorinated water (e.g. surface, well)

☐ ☐ ☐ ☐ Recreational water exposure (e.g. lakes, rivers, pools, wading pools, fountains)

☐ **Patient could not be interviewed**

☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

☐ Initiate traceback investigation

☐ Other, specify: _____

NOTES

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____ **Record complete date** ___/___/___

Cyclosporiasis: case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered